MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (X) HCP ( ) IE ( ) IC	**Response Timely Filed?** (X) Yes ( ) No
Requestor Surgical and Diagnostic Center, LP 729 Bedford Euless Road West, Ste. 100 Hurst, TX 76053	MDR Tracking No.: M4-04-0027-01 TWCC No.: Injured Employee's Name:
Respondent American Protection Insurance Co. Rep. Box # 39	Date of Injury: Employer's Name: Scotsman Industries Inc. Insurance Carrier's No.: 4650112020

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
10-3-02	10-3-02	**62284, 72110**	**$1298.63**	**$0.00**
		Insurance carrier's payment (subtracted)		**<$506.49>**

PART III: REQUESTOR'S POSITION SUMMARY

Our charges are fair and reasonable based on another insurance companies determination of fair and reasonable payments of 85 – 100% of our billed charges. Workers' Compensation carriers are subject to a duty of good faith and fair dealing in the process of worker's compensation claims.

PART IV: RESPONDENT'S POSITION SUMMARY

The total reimbursement by the carrier was $506.49. The total amount in dispute is $1298.63. Surgical and Diagnostic Center has failed to meet it's burden of proof to establish that its charges are fair and reasonable and the reimbursement it seeks comply with the Texas Workers' Compensation Act or the TWCC Rules.

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

This dispute relates to services provided in an Ambulatory Surgical Center that are not covered under a fee guideline for this date of service. Accordingly, the reimbursement determined through this dispute resolution process must reflect a fair and reasonable rate as directed by Commission Rule 134.1. This case involves a factual dispute about what is a fair and reasonable reimbursement for the services provided.

On 10-3-02, claimant underwent lumbar myelogram.

After reviewing the documentation provided by both parties, it appears that the respondent provided persuasive information that supports that their recommended amount is fair and reasonable. The respondent used a methodology that considered varied factors/data and adequately outlines that how the derived reimbursement amount represents a fair and reasonable payment. It does not appear that the requestor provided convincing documentation that sufficiently discusses, demonstrates, and justifies that their purported amount is a fair and reasonable reimbursement (Rule 133.307). Based on the documentation contained in this dispute and both parties' positions, it is clearly evident that the fair and reasonable reimbursement is the amount recommended by respondent.

Considering the reimbursement amount calculated in accordance with the provisions of rule 134.1 compared with the amount previously paid by the insurance carrier, we find that no additional reimbursement is due for these services.

PART VI: COMMISSION DECISION

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is not entitled to additional reimbursement.

Findings and Decision by:

	Elizabeth Pickle, RHIA	August 11, 2005
Authorized Signature	Typed Name	Date of Order

PART VII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on ___19_____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART VIII: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____